CONNECTICUT HEALTHCARE INNOVATION PLAN

Equity and Access Council

Design Group 1: Cost Benchmark Calculation (1B)

Workshop 3

March 6th, 2015

Meeting Agenda

Item	Allotted Time
1. Introductions	5 min
2. Public Comment	5 min
3. Overview of Design Group Process	5 min
4. Discussion of Cost Benchmark Calculation	35 min
5. Synthesis of Cost Benchmark Initial Hypotheses	10 min

3. Two Categories of Safeguards

CT's Process

1. **Evaluate evidence** for the hypothesized risks and options for preventive safeguards
2. **Establish safeguards** (incentives, policies, and processes) that prevent under-service and patient selection
3. **Implement** safeguards
4. **Monitor** and analyze results
5. **Adjust** safeguards based on lessons learned

What types of safeguards can be built into the proposed payment reforms?

We propose two categories of safeguards:

1. Payment design features

Concept:

Design new payment methods in a way that, taken together, do not create incentives for under-service and patient selection

2. Supplemental safeguards

Concept:

Establish additional rules and processes to deter and detect under-service and patient selection

3. Design Elements of Safeguards

1. Payment Design Features

Safeguard Type		Description	Hypothesis
A	*Attribution of patients*	The method by which patients are assigned to a provider	How patients are assigned to an ACO will impact the ability to conduct improper patient selection
B	*Cost benchmark calculation (cost benchmarks & risk adjustments)*	The method by which a patient's benchmark (expected) cost of care is determined and adjusted for clinical and other risk factors	Creating benchmarks that accurately reflect patients' expected cost of care – or that exceed expected cost of care for patients at greatest risk of being selected against – will minimize improper patient selection
C	*Provider payment calculation*	Other elements of the formula that defines the amount of incentive payments generated for a given patient population	Balanced financial incentives that make providers financially indifferent to providing more care vs less care will lead providers to provide the right care, minimizing the risk that medically appropriate services will be withheld
D	*Payment Distribution*	The method by which individual providers share in savings achieved	Rewarding providers based on ACO performance, rather than individual performance, will minimize any incentive for a provider to withhold appropriate services, while facilitating monitoring for improper behavior

3. Design Group Milestones and Timing

We will organize the agenda of upcoming EAC meetings around review of outputs for each of the four design groups.

WORKSTREAM/ACTIVITY	January				February				March					April			
	Week of:				Week of:				Week of:					Week of:			
	5	12	19	26	2	9	16	23	2	9	16	23	30	6	13	20	27
Group 1 - 1A-B: Attribution, risk adjustment, cost benchmarking				M1	R1	M2			M3	R2							
Group 2 - 1C-D: Performance-based payment calculation & distribution							M1			R1	M2	R2					
Group 3 - 2A-B-C: Rules, communication, enforcement							M1			R1	M2	R2					
Group 4 - 2D-E: Retrospective & concurrent monitoring						M1		R1	M2	R2							

Today

Report containing Phase I recommendations

M1 **Design milestone/workshop 1**

M2 **Design milestone/workshop 2**

M3 **Design milestone/workshop 3**

R1 **EAC initial review/input**

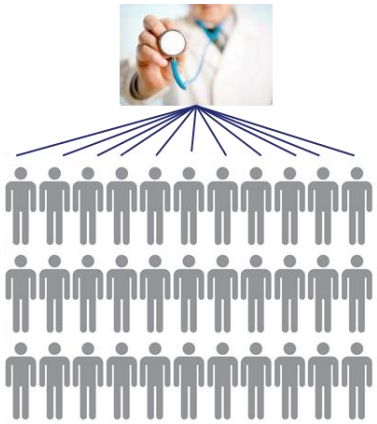
R2 **EAC final review/input**

3. Design Group Process

Design Phase	All Design Groups	Progress
Workshop 1	Goal: Evaluate existing research and evidence and establish initial hypotheses Content: Synthesis of research on topic and input from experts for group to discuss, provide input, and establish a point of view	X
Review 1	Goal: Feedback and reactions from EAC on initial hypotheses and suggestions on areas of further exploration and/or revision Content: Present initial hypotheses from design group, review relevant materials, and pose any questions/concerns from the design group where EAC input was desired	X
Workshop 2	Goal: Develop draft recommendations based on additional research and EAC feedback Content: Synthesis of feedback from EAC and additional research required for group to provide input and establish a final recommendation	X
Workshop 3	Goal: Develop draft recommendations based on additional research and EAC feedback Content: Synthesis of feedback from EAC and additional research required for group to provide input and establish a final recommendation	
Review 2	Goal: EAC to adopt recommendations Content: Present revised recommendations from design group and pose any final questions for EAC input	

4. Cost Benchmark Calculation Overview

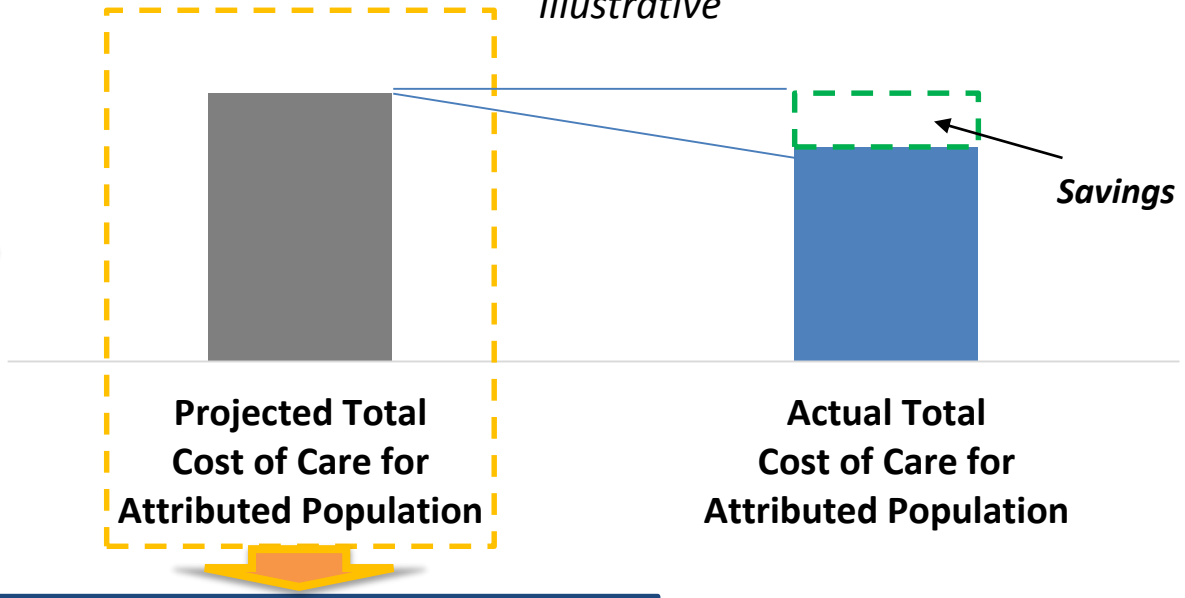
1B. Cost Calculation (cost benchmark & risk adjustment)	**Future cost estimation for population of patients attributed to a provider, from which shared savings calculations are determined**



Population Attributed to a Provider

How Shared Savings Are Calculated

Illustrative



Projected Total Cost of Care for Attributed Population

Actual Total Cost of Care for Attributed Population

How is the projected cost for the attributed population determined?

Step 1: Define population used to determine cost benchmark

Step 2: Risk adjust cost benchmark

4. Cost Benchmark Calculation Overview

1B. Cost Calculation (cost benchmark)	**Population of patients used to determine cost benchmark for shared savings program**

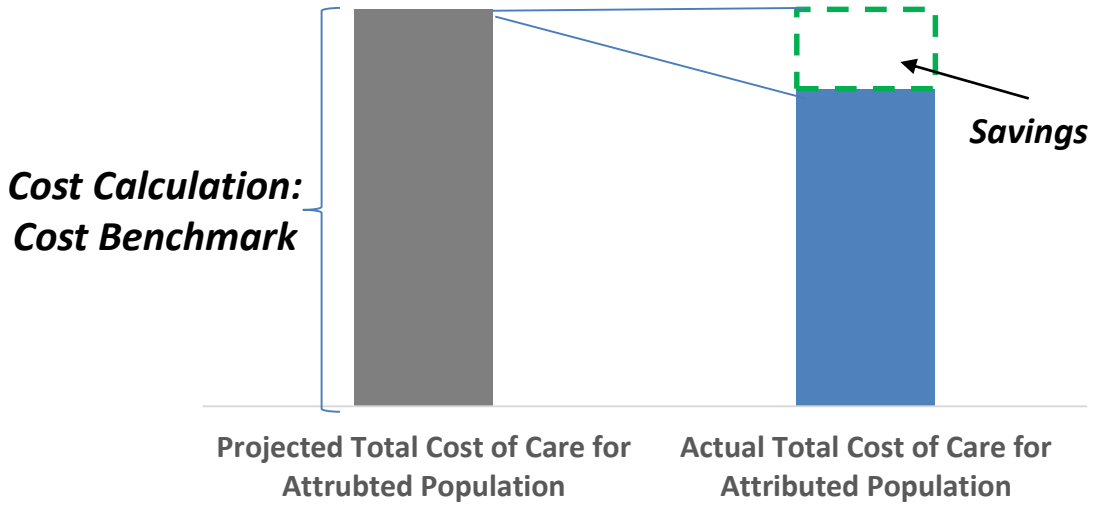
Step 1: **Define population used to determine cost benchmark**

1 Historical Costs:
Uses past patient experiences of population attributed a provider to project future expenses for that population.

2 Control Group Costs:
A comparator group that ***is not*** based on the past experiences of the patients in the shared savings program. Control groups can be based on:

- What is considered to be best practice in the region
- The broader regional provider network, or
- A comparator group that is deemed to be similar

How Shared Savings Are Calculated
Illustrative



4. Cost Benchmark Calculation Overview

1B. Cost Calculation (risk adjustment)	**Additional method used to adjust future shared savings cost projections that accounts for the overall risk of the population as part of the cost projection. Risk adjustment takes into consideration demographics and the diagnoses of the population.**

Step 2: **Risk adjust the cost benchmark**

Will the need for risk adjustment vary depending on the cost benchmark method?

Cost Benchmark Method	Role of Risk Adjustment
Historical Costs	• A historical cost benchmark will inherently account for risk as it is based on the actual prior care experiences of the attributed population. • However, adjustment can be valuable as a way to more accurately predict how future costs are likely to vary from the historical snapshot.
Control Group Costs	• Unlike the historical cost benchmark, the control benchmark is based off of a population that is ***not part*** of the shared savings program and will not inherently account for the attributed population's level of risk. • Risk adjustment provides an essential method to reflect the impact of risk on the cost benchmark, providing for an "apples to apples" comparison.

Beyond the risk adjustment method used, the timing of the adjustment (i.e.; concurrent vs prospective) and supplemental methods (e.g.; cost outlier adjustments, enhanced payments and service exclusions) should be considered

4. Cost Benchmark Calculation Overview

Council and Design Group discussions on this topic have largely focused on how to appropriately risk adjust the cost benchmark, and on additional contract elements that exist today that are used to account for patient risk.

What do most risk adjustment methodologies tend to adjust for today?	CMS: *CMS accounts for basic demographics (i.e.; age) and the acuity of diagnoses, but does not account for social determinants of health.* ACG, Verisk Health: *There are several proprietary methods used by various commercial payers to adjust for risk. However, all elements accounted for are not publicly available.*
How are risk adjustment methods applied?	CMS: *CMS uses patient age to annually adjust the risk adjustment factor. It uses decreases in beneficiary acuity to adjust cost benchmarks downward, but it does not adjust benchmarks upward in response to increases in acuity.*
What supplemental methods are in use today?	Vermont, CMS: *VT Medicaid ACOs and CMS truncate high cost claimants at the 99th percentile.* BCBS: *BCBS of Michigan rewarded providers for care management for patients with chronic conditions. This resulted in improved quality and lower cost.* Oregon.gov: *Oregon providers are working toward developing a socioeconomic adjustment factor as a rationale for enhanced payments.*

4. Cost Benchmark Calculation Implications

How will the cost benchmark used to determine shared savings impact the risk for patient selection and under-service?

A proposed hypothesis is….

Providers who feel adequately reimbursed for caring for more complex and high risk patients will have no incentive to avoid complicated patients and will have no incentive to stint on care for those patients.

1. **What elements must risk adjustment contain to meet the standard stated above?**

2. **What challenges might prevent a risk adjustment methodology from adequately adjusting for risk and the associated resources required to care for a patient population?**

3. **Which additional contract features that account for risk can help overcome the challenges of using inherently imperfect risk adjustment methodologies?**

   Examples of risk-related contract features include: truncation of high-cost claimants, provision of a supplemental care management per member per month fee and exclusion of high cost services/procedures

5. Synthesis of Initial Hypotheses

Objectives:

*1. **Summarize initial hypotheses** to share with the EAC on what its recommendations should say about design of patient attribution methods and cost calculation benchmarks to safeguard against patient selection and under-service.*

*2. **Recommend discussion topics and material** to support the EAC's discussion on these topics at its 2/5 meeting*

Applies to…..

1B. Cost Benchmark Calculation	Patient Selection	Under-Service
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐